

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4709-62-034805
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

FILED SEP 28 1962

VS 300
Rev. 4/59

1

3

4 0

5 1

6

7 1

8 2

9 527.1

10

11

12 65-0

13

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 20 yrs	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If outside, give location) 6705 Winner Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Milford W. Howell		4. DATE OF DEATH Month Day Year Sept. 10 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1909
9. AGE (last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (City and state or country) Pikeville, Ky		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Hayes Howell		13b. MOTHER'S MAIDEN NAME Maggie Stewart	
14. NAME OF HUSBAND OR WIFE Mattie Lee Howell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address K. C. Mo. Mattie L. Howell, 6705 Winner Road	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 1 day 2 mos	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9/4/62 to 9/10/62 and last saw him alive on 9/10/62. Death occurred at 11:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) W. W. Buckingham M.D. 22b. ADDRESS 314 Pryor Bldg. 22c. DATE SIGNED 9/17/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-13-1962	
23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) Kansas City, Missouri	
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc Blue Ridge & Gregory		25. DATE RECD. BY LOCAL REG. 9-14-62	
26. REGISTRAR'S SIGNATURE Ruth Long			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

If this body is not embalmed, fact should be so stated above.